



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BROWN SPINE & SPORTS CHIROPRACTIC

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-16-0346-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

OCTOBER 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our initial claim submission was submitted in a timely manner – see the attached claim correspondence which stated that our claim was incomplete. Box 32 needed to be populated and was not. The billed date stated 01/20/2015 which was within time from for DOS 12/29/14. Claim history for our sys database shows all claims activity. These claims were all filed in accordance with TDI's Division of Workers' Compensation and after receiving the following denials with no resolve between the payer and health care provider; a medical dispute resolution is being file for assistance in this matter."

Amount in Dispute: \$3,117.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Brown Spine & Sports Chiror is not entitled to reimbursement for date(s) of service 12/29/14 – 03/19/15 in the amount of \$3,117.00 based on failure to accurately and timely submit a complete medical bill in accordance with health care provider billing rules set forth under 28 TAC Chapter 133 General Medical Provisions. In the event the divisions finds that the requestor qualifies for medical fee dispute review CorVel further maintains the requestor failed to appropriately submit a request for preauthorization in accordance with division rules set forth under 28 TAC Chapter 134."

Response Submitted by: CORVEL HEALTHCARE CORPORATION

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2014 through January 16, 2015	CPT Code 97010 (Six dates of service)	\$60	\$0.00
December 29, 2014 through January 26, 2015	CPT Codes 99201, 97014, 97110, 97140, 97012, 97530, 97201 and 99211	\$3,057.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. 28 Texas Administrative Code §134.203 sets out fee guideline reimbursement for professional services.
5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Service lacks info needed or has billing error(s).
 - 29 – Time limit for filing claim/bill has expired.
 - RG3 – Included in another billed procedure.
 - RM7 – Invalid code for CMS payment-resubmit with valid code.
 - P14 – Payment is included in another svc/procedure occurring on same day.
 - 59 – Distinct Procedural Service.
 - W3 – Appeal/Reconsideration.
 - 197 – Payment adjusted for absence of precert/preauth.

Issues

1. Did the requestor bill a physical therapy code that is a Status “B” code?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The health care provider billed CPT Code 97010 – Hot/Cold Packs. The insurance carrier denied the disputed code with claim adjustment reason codes: 59 – “Distinct Procedural Service”; RG3 – “Included in another billed procedure”; P14 – “Payment is included in another svc/procedure occurring on same day”; and W3 – “Appeal/Reconsideration.” In accordance with 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. CPT Code 97010 is considered a Status B - bundled code and is not priced by Medicare; therefore, reimbursement is not recommended.
2. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing claim/bill has expired.”; W3 – “Appeal/Reconsideration.”; 197 – “Payment adjusted for absence of precert/preauth.”; and 59 – “Distinct Procedural Service.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.0272(b) provides that:

Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
 - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

- (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
- (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

- 3. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted information finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	November 5, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.